**STATE OF MICHIGAN**

**DEPARTMENT OF LABOR & ECONOMIC GROWTH**

**OFFICE OF FINANCIAL AND INSURANCE REGUALTION**

**Before the Commissioner of Financial and Insurance Regulation**

**In the matter of**

**XXXXX**
**Petitioner** **File No. 88669-001**

**v**

**Blue Care Network of Michigan**
**Respondent**
_____/

**Issued and entered**
**This 23rd day of June 2008**
**by Ken Ross**
**Commissioner**

**ORDER**

## I
## PROCEDURAL BACKGROUND

On March 21, 2008, XXXXX, on behalf of her minor son XXXXX (Petitioner), filed a request for external review with the Commissioner of the Office of Financial and Insurance Regualtion (Commissioner) under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On March 28, 2008, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

Initially this case appeared to involve only contractual issues so the Commissioner did not assign it to an independent review organization (IRO) for review by a medical professional. Upon further evaluation the Commissioner determined this case would benefit from review by an outside expert and assigned it to an independent medical reviewer. On April 29, 2008, the IRO completed its review and sent it to the Office of Financial and Insurance Regulation.

## II
## FACTUAL BACKGROUND

The Petitioner has been diagnosed with Fragile X syndrome, a genetic condition

involving changes in part of the X chromosome. It is the most common form of inherited mental retardation in males and a significant cause of mental retardation in females.

In October 2007, Dr. XXXXX, Petitioner's primary care physician, requested coverage for a consultation with Dr. XXXXX (an out-of-network provider) and for speech therapy at XXXXX Hospital. BCN denied both requests but the Petitioner proceeded with treatment.

The Petitioner pursued BCN's internal grievance process and received BCN's final adverse determination in a letter dated March 14, 2008.

## III
## ISSUE

Did BCN properly deny the Petitioner coverage for the XXXXX consultation and speech therapy at XXXXX Hospital?

## IV
## ANALYSIS

Petitioner's Argument

The Petitioner's mother contends that coverage should be provided for the consultation with Dr. XXXXX because she is the only Fragile X specialist in the United States. She says the speech therapy should be covered because she was never told that her son's condition was chronic or developmental. Therefore, she does not believe that BCN has the right to deny therapy on that basis. She says that if her son is denied therapy he will be rendered mute. She believes the therapy is medically necessary as it will train her son to work the muscles in his face in order to learn to speak. Petitioner's treating physicians and specialists all agree that the therapy is medically necessary. Dr. XXXXX wrote in a February 8, 2008, letter to Petitioner's primary care physician:

> His behavior now includes sitting at 9 months, crawling at 14 months, walking at 23 months, and he said "mama" and "dada" at about 14 months, but has not advanced in his language except for approximating the word "milk." The family feels he regressed and that he used to be able to say "daddy" clearly and now just says "dada." He has

> intermittently poor eye contact. He now wanders quite a bit and has a relatively short attention span. . . .
>
> He is in an early intervention program where he receives early intervention twice a week. He also receives one hour PT therapy and one hour of OT therapy per week, but he has not yet received speech and language therapy and that is very problematic. It is a medical necessity for him to have speech and language therapy as soon as possible because of his significant delays.
>
> * * *
>
> I am very concerned about autism. . . . It is essential at this point in time that he have, not only speech and language therapy twice a week, but also [applied behavior analysis therapy] which is important for individuals with autism.

Petitioner's geneticist wrote in a letter to his parents:

> [I]t is clear that his marked developmental delay will require ongoing and intensive speech therapy; that his ocular abnormalities will require ongoing ophthalmologic follow-up; that his motor apraxia will require ongoing neurological follow-up; that this failure to pass his newborn hearing screen and the subsequent inability to document unequivocally normal hearing will require ongoing audiologic and, very probably, otolaryngologic follow-up; and that the question of whether [Petitioner] may have a second underlying genetic condition in addition to his FXS will require ongoing genetic follow-up… Although some children with FXS may not have unusual medical difficulties, [Petitioner] clearly does have unusual medical difficulties; I support your effort to have [him] found medically eligible for services. . . .

Respondent's Argument

In its final adverse determination, BCN denied coverage for speech therapy, stating, "The requested speech therapy is considered [treatment for] a chronic and developmental condition and it is not covered under our Blue Care Network (BCN) medical policy and your BCN 1 certificate."

Coverage for the consultation with Dr. XXXXX was denied because Petitioner had not received prior approval for the out-of-network consultation as required in the Member Handbook, page 15.

Commissioner's Review

The issue in this case is whether BCN properly denied coverage for speech therapy services. The following provisions apply to this case.

The BCN certificate of coverage describes the requirements for receiving coverage for speech therapy services:

> **I. SCHEDULE OF BENEFITS**
>
> ***1.14 PHYSICAL THERAPY AND REHABILITATION SERVICES***
>
> We cover medically necessary short-term outpatient physical therapy and medical rehabilitation services, including speech therapy, when authorized by the health plan. This benefit is limited to 60 visits per medical episode per plan year. Covered in full.

BCN's medical policy, "Speech/Swallowing Therapy" includes the following provisions:

> **Inclusionary and Exclusionary Guidelines**
> Short-term outpatient speech therapy is covered under all BCN certificates when:
>
> * * *
>
> - Coverage is available for treatment of an acute exacerbation of a chronic condition that is subject to significant improvement within 60 days.
>
> * * *
>
> Coverage Exclusions
> - Speech therapy is not covered for chronic conditions or developmental speech abnormalities.
> - Speech therapy for verbal apraxia (The impairment of voluntary production of speech sounds in the absence of sensory loss or paralysis sufficient to explain the impairment) or stuttering/stammering is not covered unless due to a specific disease or brain injury.

BCN requires prior approval for any consultation with a provider outside the BCN provider network. The BCN Member Handbook (page 15) states, "You must have a referral from your primary care physician before you get care from providers who are not part of the BCN network, and BCN must authorize the care."

To help the Commissioner resolve the medical issues presented by this case, the matter was assigned to an IRO for the recommendation of an expert. The IRO physician reviewer is

board certified in pediatric neurology and holds an academic appointment. The reviewer who is familiar with the medical management of patients with the member's condition recommended upholding BCN's denial of coverage. The IRO reviewer said, "Fragile X syndrome is an inherited condition and is therefore chronic in nature…there is no evidence in the case file that demonstrates the member had an acute exacerbation in his condition." The IRO reviewer concluded that the speech therapy being provided was for a chronic condition.

The Commissioner is not required in all instances to accept the IRO's recommendation. However, the IRO recommendation is afforded some deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the Commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16)(b) The IRO's analysis is based on extensive expertise and professional judgment. The Commissioner can find no reason why that judgment should be rejected.

Regarding the out-of-network consultation with Dr. Hagerman, the Commissioner notes that BCN had not given authorization for that evaluation. Therefore, the cost of the consultation is not a covered benefit.

The Commissioner finds that BCN has properly applied the provisions of its certificate of coverage.

## V
## ORDER

The Commissioner upholds BCN's March 14, 2008, final adverse determination.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court

of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.